MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

011443

Reg. Diat. No. 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Cecil

City or town: Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice Ann Alexander

3.(b) Social Security Number

4. Sex: Fe.

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: William Alexander

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 13 - 1874

8. AGE: Years: 72 Months: Days: 1 If less than one day: ..... hrs. ..... min.

9. Birthplace: Loveland Isle Wight Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Rafe Grant

FATHER 13. Birthplace: Cecil Co. Md.

MOTHER 14. Maiden name: Elizabeth Gale

MOTHER 15. Birthplace: Cecil Co. Md.

16. Informant: Agnes Caldwell

Address: Rising Sun Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19 1946 (month) (day) (year)

Cemetery or crematory: Trinity

Location: Zion Md

18. Funeral director: C P Rogers

Address: Rising Sun

19. Jan 17 1946 (Date rec'd by registrar) L M Worthington Registrar

Corrected issued 1-17-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1946, at 2.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to: Hypertension	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R L Dodson M.D. (Medical Examiner for Cecil County)

M. D. or other

Address: Rising Sun Md. Date signed 1-14-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (128)

CERTIFICATE OF DEATH

★ 00444 Reg. Dist. No. 9 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Union Hospital, Elkton, Md.
How long in hospital or institution? 10 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil Co.
City or town: North East Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Realy Anderson.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Mrs. Elizabeth Anderson 6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): July 27 1909

8. AGE: Years	Months	Days	If less than one day
36 years	5	19	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Unable to work.

11. Industry or business

FATHER 12. Name: Burl E. Anderson

13. Birthplace: N. C.

MOTHER 14. Maiden name: Sarah Galloway

15. Birthplace: N. C.

16. Informant: Elizabeth Anderson
Address: North East, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan 8 1946 (month) (day) (year)
Cemetery or crematory: Brookview
Location: Rising Sun Md.

18. Funeral director: J. E. Tyson
Address: Rising Sun Md.

19. 1/17 1946 Lem Worthington
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1946, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1946 to Jan 15 1946 and that I last saw h[illegible] alive on Jan 15 1946

Immediate cause of death	DURATION
Acute Pneumonia	2 weeks
Due to	
Due to	
Other conditions: Total paralysis below Lower Extremities	5 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. J. Davis M.D.
M. D. or other
Address: Chesapeake Md. Date signed: 1/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

06445

Reg. Dist. No. 95

1. PLACE OF DEATH:
County Cecil
City or town Rowlandsville, (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 y
Hospital, institution, or street address where death occurred: Stanley nursing home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Cecil
City or town Chesapeake City (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sallie Armbrester

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Albert Armbrester
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) Oct 17 1871

8. AGE: Years	Months	Days	If less than one day
74	2	16	...... hrs. ...... min.

9. Birthplace Chesapeake City Md (Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name Samuel Simmons
13. Birthplace Elkton Md R D

MOTHER
14. Maiden name Mary Jane Lum
15. Birthplace Elkton Md R D

16. Informant Clara A Castle
Address Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 1946 (month) (day) (year)
Cemetery or crematory Bethel Cemetery
Location Bethel near Chesapeake City Md

18. Funeral director H W Pippin
Address Elkton Md

19 January 5th 1946 (Date rec'd by registrar) Mrs Ralph H Bell Registrar

1-8-46 L M Worthington

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 19 46, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept -12 19 45, to Dec -31- 19 45 and that I last saw h er alive on Dec - 31 - 19 45.

		DURATION
Immediate cause of death	Chronic Myocarditis	8 yrs
Due to		
Due to		
Other conditions	Arterio Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. J. Benson M.D. M. D. or other
Address Port Deposit, Md Date signed 1/3/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 11928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Phoebe Barrington

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: John Barrington
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Sept 13 - 1889
8. AGE: Years: 56 Months: 2 Days: 17 If less than one day: ..... hrs. ..... min.
9. Birthplace: North East - Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: John McKinney
13. Birthplace: Md
MOTHER 14. Maiden name: Phoebe McHall
15. Birthplace: Penna
16. Informant: Hospital Records
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-19-46 (month) (day) (year)
Cemetery or crematory: Methodist
Location: North East Md
18. Funeral director: Joseph R Grant
Address: North East Md
19. Jan 18 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16th 1946 at 9.00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1946 to Jan 16 1946 and that I last saw her alive on Jan 16 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Hypertension	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. McKnight M.D
M. D. or other
Address: Elkton Md Date signed 1/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

★ 00447 94

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles C Bayard

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie M Bayard

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 7 1866

8. AGE: Years	Months	Days	If less than one day
79	8	18	hrs. min.

9. Birthplace: North East Rural Md (Town, county, and state)

10. Usual occupation: Retired Merchant

11. Industry or business

FATHER — 12. Name: Charles J Bayard

13. Birthplace: Md

MOTHER — 14. Maiden name: Teresa A Steele

15. Birthplace: Md

16. Informant: Mrs Wm Conley

Address: New Castle Rural Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-30-46 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R Grant

Address: North East Md

19. 1/29 19 46 (Date rec'd by registrar) Lida V Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25th 19 46, at 7 50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 23 19 46 to Jan 25 19 46

and that I last saw h... alive on January 25 19 46

Immediate cause of death	DURATION
Congestion	
Heart Failure	
Due to: Lobar Pneumonia	
Due to:	
Due to:	
Other conditions: Erysipelas	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Elkton Date signed: 1/29/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-f)

CERTIFICATE OF DEATH

00448

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Davenport Cambliss

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Fred Cambliss
6.(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): Dec 11 1876
8. AGE: Years: 69 Months: Days: 24 If less than one day: hrs. min.
8. Birthplace: Chesapeake City Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Benjamin Davenport
13. Birthplace: England
MOTHER 14. Maiden name: Mahala Stubbles
15. Birthplace: Cecilton Maryland
16. Informant: Austin D Cambliss
Address: Elkton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 7 1946 (month) (day) (year)
Cemetery or crematory: Bethel cemetery
Location: Chesapeake City R D
18. Funeral director: H W Pusey
Address: Elkton Md
19. Jan 5 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH: January 6th 1946 at 1:45 M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 31st 1945, to Jan 4th 1946
and that I last saw h... alive on Jan 3rd 1946

	DURATION
Immediate cause of death: Intestinal obstruction	1 wk
Due to: Hypertension CVD	3 yrs
Due to: Gall Bladder	
Other conditions: chronic myocarditis	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Elkton Md Date signed: Jan 5 '46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00449

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH

County: Cecil

City or town: Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Eliza Jane Carter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Cortley Carter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 26 1872

8. AGE: Years	Months	Days	If less than one day
73	10	1	..... hrs. ..... min.

9. Birthplace: Grant Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Preston Parks

FATHER — 13. Birthplace: Va.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Mr. Cleon Carter

Address: Rising Sun R.F.D.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Jan 30 1946 (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora

18. Funeral director: L. A. Tyson

Address: Rising Sun Md

19. Jan 29 1946 (Date rec'd by registrar) L M Worthington Registrar

Permit issued 1-29-46

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1946 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral	
accident	
Due to	
Due to	
Other conditions	

(Incindo pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R C Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address: Rising Sun Md Date signed 1/28-46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01450

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 North Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Virginia Chambers

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

B.(b) Name of husband or wife: James Chambers
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): Apr 1 1871

8. AGE: Years	Months	Days	If less than one day
74	9	2	...hrs. ...min.

9. Birthplace: Chester Pa
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Wm Crothers
13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah Mullen
15. Birthplace: no information
18. Informant: Margaret Stigle
Address: Wilmington, Del
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 6 1946 (month) (day) (year)
Cemetery or crematory: Elkton Cemetery
Location: Elkton Md
18. Funeral director: H. W. Rippin
Address: Elkton Md
19. Jan 5 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3, 1946 at 10:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20, 1945 to Jan. 3, 1946
and that I last saw her alive on Jan. 3, 1946
Immediate cause of death: Myocarditis — DURATION
Due to: Cardiovascular renal disease
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dr. Ford H. Doneker, M.D.
M. D. or other
Address: Elkton, Md. Date signed: 1/4/46

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

CERTIFICATE OF DEATH

06451

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: 221 West Main

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 221 West Main

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME A John Clark

3. (b) Social Security Number 221-01-5650

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Cleta Clark

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Aug 29 1891

8. AGE: Years	Months	Days	If less than one day
54	4	24	...hrs. ...min.

9. Birthplace: Elkton Cecil Maryland (Town, county, and state)

10. Usual occupation: accountant

11. Industry or business

FATHER — 12. Name: James A Clark

13. Birthplace: Elkton. Maryland

MOTHER — 14. Maiden name: Catherine W Johnson

15. Birthplace: Wilmington Delaware

16. Informant: James A Clark

Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 25 1946 (month) (day) (year)

Cemetery or crematory: Elkton Cemetery

Location: Elkton Md

16. Funeral director: H. W Pippin

Address: Elkton Md

19. Jan 23 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 22 1946 at 3:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 7 1945 to Jan. 22 1946 and that I last saw him alive on Jan. 22 1946

Immediate cause of death	DURATION
Gastric Hemorrhage	
Due to: Cirrhosis of Liver	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Orland H. Spreacher, M.D. M. D. or other

Address: Elkton, Md. Date signed: Jan. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00452

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 6 mos. 11 days

Hospital, institution, or street address where death occurred:
Veterans Administration Hospital

How long in hospital or institution? 9 yrs. 6 mos. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 610 H St., S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: COLLINS, Michael

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 2, 1895

8. AGE: Years: 50 | Months: 8 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Painting

FATHER
12. Name: Morris J. Collins
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Mary Burke
15. Birthplace: Maryland

16. Informant: Records - Veterans Administration,
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof January 30, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery,
Location: Fort Myer, Virginia

18. Funeral director: Lee A Patterson & Son.
Address: LEE A. PATTERSON & SON
Perryville, Maryland

19. Jan 30 19 46 (Date rec'd by registrar) Irene E. Dunlap Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 19 46, at 8:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Tuberculosis, pulmonary, far adv., active "2"	over 6 mos.
Due to	
Due to	
Other conditions: General Paralysis of the Insane	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: A. E. TROLLINGER, LT. COL., MC, U.S.A. DIR.

Address: Vets. Admin., Perry Point, Md. Date signed: 1-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00453

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md. U.S. Veterans Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo. 17 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Chestertown, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ...
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: COOPER, Arthur R.

3.(b) Social Security Number: 212 - 10-9021

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara Cooper

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): January 6, 1896

8. AGE: Years	Months	Days	If less than one day
50		6	...hrs. ...min.

9. Birthplace: Kent County, Md.
(Town, county, and state)

10. Usual occupation: Printer

11. Industry or business: —

FATHER 12. Name: George Thomas Cooper

FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Priscilla Meekins

MOTHER 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. (Burial, cremation, or removal. Which?) Removal and Burial Date thereof (month) 1-22-46 (day) (year)

Cemetery or crematory: Chester Cemetery

Location: Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. (Date rec'd by registrar) Jan 22 19 46 Irma E. Dunfee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 19 46 at 12:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19 45 to January 22 19 46 and that I last saw him alive on January 22 19 46

Immediate cause of death	DURATION
Myocardial Degeneration due to	
coronary arteriosclerosis	over 6 mo.
Due to	
Due to	
Other conditions: Psychosis, unclassified	Over 6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. ...

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of ...

Where did injury occur? ... (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: C. E. Brockington M. D. or other

Address: E. PROCTOR, Lt. Col., M.C., Clinical Director, Veterans Administration, Perry Point Md.

Date signed: 1-22-46

00454

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH (89a)

County Kent Registration Dist. No. 90

Village or City Near Wareneka No. General St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Adeline Lockman Crawford If U. S. Veteran, specify WAR

(a) Residence: No. Middletown R.D. Del St., Ward.
(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Archer Crawford

6. DATE OF BIRTH (month, day, and year) July 27 1882

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Maryland
(State or country)

FATHER

13. NAME Dan M. Cochran

14. BIRTHPLACE (city or town)
(State or country) Delaware

MOTHER

15. MAIDEN NAME Adeline Wilson

16. BIRTHPLACE (city or town)
(State or country) Maryland

17. INFORMANT Archer Crawford
(Address) Middletown Del R.D.

18. BURIAL, CREMATION, OR REMOVAL
Place Forest Cem. Middletown, Del Date 1-27, 1946

19. UNDERTAKER Edward Williams
(Address) Middletown, Md.

20. FILED Jan 25, 1946 Irving J. Temple
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 24 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from January 19, 1946, to January 25, 1946

I last saw h-- alive on Jan. 23, 1946; death is said to have occurred on the date stated above, at 4 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage with Left Hemiplegia	Jan. 19, 1946
Other Contributory Causes of Importance:	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Wallace C. Denn M. D.

(Address) Middletown, Del

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

Reg. Dist. No. 00455

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 7 years.

Hospital, institution, or street address where death occurred:

c/o Thos Keithley, Elkton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton, R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Crothers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George R. Crothers

deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): about 1939 1862

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
83 yrs 1862	3	3		

9. Birthplace: Cecil County, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: George Henry Cowan
13. Birthplace: Ireland.

MOTHER
14. Maiden name: Sarah Cowan
15. Birthplace: Ireland

16. Informant: Mrs. Thomas Keithley
Address: Elkton, Md. R.D.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan 15 1946 (month) (day) (year)

Cemetery or crematory: Silver Brook

Location: Wilmington Del

16. Funeral director: H C Wiggins

Address: Elkton Md

19. Jan 16 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1946 19 at 11.50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2d 1942 19 to Jan. 11, 46 19

and that I last saw her alive on Dec. 16, 1945 19

	DURATION
Immediate cause of death: Chronic endocarditis about	4 yrs.
Due to: General arteriosclerosis	Unknown
Due to:	
Other conditions:	

(include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. H. McHugh M. D. or other

Address: Elkton Md Date signed Jan 11-46

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-8)

CERTIFICATE OF DEATH

00456

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: John Daniel

3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: White (MALE)
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: No information
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 11 - 1870
8. AGE: Years: 75 Months: 7 Days: 6 If less than one day: ..... hrs. ..... min.
9. Birthplace: Georgia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Marion Daniels
13. Birthplace: —
MOTHER 14. Maiden name: Lucilla Barnes
15. Birthplace: —
16. Informant: Hospital Records
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19-46 (month) (day) (year)
Cemetery or crematory: Methodist
Location: North East, Md
18. Funeral director: Joseph R Grant
Address: North East Md
19. Jan 18 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17 1946 at 7.00 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1946 to Jan 17 1946 and that I last saw h.. alive on Jan 16th 1946
Immediate cause of death: Chronic Hepatitis with final circulatory failure — DURATION: Unknown
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. H. McNeagle M. D. or other
Address: Elkton - Md Date signed: Jan 17-1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 00457 2

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 wks
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 2 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Chesapeake City
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veleran, name war

3. (a) FULL NAME: Isaac M Dean

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Lizzie Dean
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 12 1857

8. AGE: Years 88 | Months 8 | Days 1 | If less thao one day ... hrs. ... min.

9. Birthplace: Princis Cecil Maryland
(Town, county, and state)

10. Usual occopation: Farmer

11. Industry or business

FATHER
12. Name: Jacob Dean
13. Birthplace: Liverpool England

MOTHER
14. Maiden name: Elizabeth Colmery
15. Birthplace: Elkton Md R D

16. Informant: Andrew D Dean
Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16 1946 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: Chesapeake City R D

18. Funeral director: H. W. Pippin
Address: Elkton Md

19. Jan 15 1946 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1946, at 12 09 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 1945 to Jan 13 1946 and that I last saw h... alive on Jan 13 1946

Immediate cause of death	DURATION
Uremia	2 weeks
Due to: Chronic nephritis	several years
Due to:	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Antopsy results: ...
PHYSICIAN: Pleaso underlino tho cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: H. J. Downs M.D.
M. D. or other
Address: Chesapeake City Md Date signed 1/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 01975

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hosp.
How long in hospital or institution? four minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro lofants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton RD 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clinton Denny

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	widowed

6.(b) Name of husband or wife: Susana Denny
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): aug 12, 1870

8. AGE: Years: 75 | Months: 5 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkton Cecil Maryland
(Town, county, and state)

10. Usual occupation: Fisherman

11. Industry or business:

FATHER
12. Name: Henry W Denney
13. Birthplace: Elkton md

MOTHER
14. Maiden name: Jane Hyatt
15. Birthplace: Elkton Md

16. Informant: Esther D. Adams
Address: 125 E 4th Chester Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 21 '46 (month) (day) (year)
Cemetery or crematory: Bethel cemetery
Location: Chesapeake City Md

18. Funeral director: H W Lippincott
Address: Elkton. Md

19. Jan 19 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 18 1946 at 1.15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: R L Dodson MD M. D. or other
Address: Elkton Md Date signed: 1-18-46

Medical Examiner Cecil County

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

00459

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? At work

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit, R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Glenn A. Downin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nellie M. Downin

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): July 9, 1892

8. AGE:	Years	Months	Days	If less than one day
	53	6	1	...hrs. ...min.

9. Birthplace: Hagerstown (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Power House, U.S. Vet. Adm.

FATHER — 12. Name: Charles Willard Downin

FATHER — 13. Birthplace: Hagerstown

MOTHER — 14. Maiden name: Sarah V. Fagley

MOTHER — 15. Birthplace: Maryland

16. Informant: Nellie M. Downin

Address: Port Deposit, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 13 1946 (month) (day) (year)

Cemetery or crematory: West Nottingham Cemetery

Location: Colora, Maryland

18. Funeral director: Lee A. Patterson & Son.

Address: Perryville, Md.

19. Jan. 12, 1946 (Date rec'd by registrar) Irma E. Dunlap Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1946 at 4:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Acute coronary thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R.L. Dodson M.D. Medical Examiner for Cecil County

M. D. or other

Address: Rising Sun Md. Date signed 1-10-46

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

CERTIFICATE OF DEATH

(0460) 94

Reg. Dist. No.

1. PLACE OF DEATH:

County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Drews

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: August Drews

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years 70 | Months no information | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Finland

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Ahonen

13. Birthplace: Finland

MOTHER

14. Maiden name: No information

15. Birthplace: Finland

16. Informant: Mrs. Asa [redacted] Westerinen

Address: North East R D No 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 2 1946 (month) (day) (year)

Cemetery or crematory: Methodist

Location: North East Md

18. Funeral director: Joseph R Shaw

Address: North East Md

19. 2/2 1946 (Date rec'd by registrar) Lida D Owens Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1946, at 5:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1946 to Jan 31 1946 and that I last saw h[redacted] alive on Jan 31 1946

Immediate cause of death	DURATION
Myocarditis	1 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: [redacted]

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C Blevins M. D. or other

Address: North East Md Date signed: 2-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1647)

CERTIFICATE OF DEATH

06461

Reg. Diat. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Blythedale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Blythedale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Joseph Scott Sears.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Beulah Sears.
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): March 13 1895

8. AGE: Years	Months	Days	If less than one day
50	9	27.	...hrs. ...min.

9. Birthplace: Port Herman Cecil Co Md. (Town, county, and state)
10. Usual occupation: Steam Fitter
11. Industry or business: Retired
FATHER 12. Name: William Sears
13. Birthplace: unknown.
MOTHER 14. Maiden name: Mary A Smith
15. Birthplace: Port Herman Cecil Co Md.
16. Informant: Mrs. Beulah Sears.
Address: Perryville
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 17. 1946 (month) (day) (year)
Cemetery or crematory: Bethel cemetery
Location: Chesapeake City Md RD
16. Funeral director: H. W. Pippin
Address: Elkton Md
19. Jan. 17 1946 (Date rec'd by registrar) Irene E. Dayhoff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 10 1946, at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...1946, to ...1946
and that I last saw h... alive on ...1946

Immediate cause of death	DURATION
Epidermoid Hemmorrhage from Lacerated area	
Due to: Throat	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 1-10-46
Where did injury occur? Blythedale (City or town) Cecil (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Razor Blade. Injured at work? No

23. SIGNATURE: R. E. Dodson M.D.
M. D. or other
Medical Examiner for Cecil County
Address: Rising Sun Md. Date signed: 1-10-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00462

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 7 months

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: —

City or town: 1304 Wilcox Street, Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1304 Wilcox Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW 1

3. (a) FULL NAME: FORREST, John W.

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 3, 1895

8. AGE:

Years	Months	Days	If less than one day
50	5	16	... hrs. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Mariner

11. Industry or business: —

FATHER — 12. Name: Edward W. Forrest

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Delia (Wright) Forrest

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1-21-1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Rita Wiedfeld per H.J.

Address: RITA WIEDFELD, Funeral Director
914 Greenmount Avenue, Baltimore, 2, Md.

19 Jan. 21, 19 46 (Date rec'd by registrar) James E. Lamp, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19, 1946, at 9:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19, 1941, to Jan. 19, 1946 and that I last saw him alive on January 19, 1946

Immediate cause of death	DURATION
Coronary Arteriosclerosis,	
Myocardial damage with insufficiency	4 yrs.
Due to	
Due to	
Other conditions: Syphilis, tertiary	Over 5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: A.E. Trollinger

Address: Perry Point, Md. M. D. or other: Clinical Director, Veterans Administration Date signed: 1-21-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of date of death is shown on FILM No. I 00 FEB 1 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

00463

Reg. Diat. No. 91

1. PLACE OF DEATH:
County: Cecil
City or town: Rural Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil.
City or town: Rural Chesapeake City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lula M Gale

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 3 1860

8. AGE: Years 86 | Months 2 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: John Mosley
FATHER 13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary Kemp Eaden
MOTHER 15. Birthplace: Maryland

16. Informant: Mrs Samuel Caldwell
Address: Rural Chesapeake City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 1946 (month) (day) (year)
Cemetery or crematory: Galena
Location: Galena Md

18. Funeral director: Edward E Elborn
Address: Millington Md

19. January 28 1946 (Date rec'd by registrar) Mrs Bertha A Sears Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25, 1946 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1946, to Jan 25th 1946
and that I last saw her alive on Jan 25th 1946

Immediate cause of death	DURATION
Chronic Myocarditis	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: C. A. McKnight M. D.
M. D. or other
Address: Elkton Md. Date signed Jan 26 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

00464

Reg. Dist. No. 93

1. PLACE OF DEATH:

County: Cecil Co Md.

City or town: Colora

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Colora Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Clarence Mitchner Garvin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Stella McKinney Garvin

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): May 29 1877

8. AGE: Years	Months	Days	If less than one day
68	7	14	...hrs. ...min.

9. Birthplace: Rock Spring Cecil Co Md.

(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

MOTHER FATHER

12. Name: Benjamin Brown Garvin

13. Birthplace: Cecil Co Md.

MOTHER

14. Maiden name: Susan Rebecca Ferguson

15. Birthplace: Cecil Co Md

16. Informant: Stella Garvin

Address: Colora Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 19 1946 (month) (day) (year)

Cemetery or crematory: Brookview

Location: Rising Sun Md.

18. Funeral director: J. E. Tyson

Address: Rising Sun Md.

19. Date rec'd by Registrar: Jan 17 1946 Registered: 1-17-46 Registrar: Lemmon Twigg

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 16 1946 at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1945 to Jan 16 1946

and that I last saw him alive on Jan 13 1946

Immediate cause of death	DURATION
Carcinoma of Stomach	
Due to Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: R. L. Dorsey M.D. M. D. or other

Address: Rising Sun Md. Date signed: 1/17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01465

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours.
Hospital, institution, or street address where death occurred: Cecil Co. Gen. Hosp. Elkton, Md.
How long in hospital or institution? 5 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn infants give residence of mother)
State: Pa. County: Chester
City or town: Kennett Square
(If outside city or town limits, write RURAL and give oearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME Geraldine Hamm. | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8 1945

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
	7.	26		

9. Birthplace: West Chester, Pa. (Town, county, and state)
10. Usual occupation: Baby.
11. Industry or business
FATHER 12. Name: Ezra Hamm.
13. Birthplace: Lansing N.C.
MOTHER 14. Maiden name: Verlie Hall.
15. Birthplace: Galveston Ky.
16. Informant: Ezra Hamm. Address: Kennett Square Pa.
17. removal (Burial, cremation, or removal. Which?) Date thereof: Jan 3 '46 (month) (day) (year)
Cemetery or crematory
Location: Lansing, Grayson Co., N. C.
18. Funeral director: father Ezra Hamm
Address
19. Jan 3 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH: Jan 3 19 46 at 3-30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Dodson M.D. M. D., or other
Address: Lansdowne Md. Date signed: 1-3-46

Medical Examiner for Cecil County

46

M C

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00466 96
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 9 mo. 10 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2338 Minnesota Ave., S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: JAMES L. HENDERSON

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married-Widower

6.(b) Name of husband or wife: Unknown - Deceased

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 2-24-1868

8. AGE: Years	Months	Days	If less than one day
77	10	25	— hrs. — min.

9. Birthplace: Lowden County, Tennessee
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —

FATHER
12. Name: G.P. Henderson
13. Birthplace: Tennessee

MOTHER
14. Maiden name: Wrinkle Henderson
15. Birthplace: Tennessee

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof January 22, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Va.

18. Funeral director: Pennington & Son
Address: PENNINGTON & SON, Havre de Grace, Maryland

19. Jan. 22 19 46 Irma E. Hayes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 19 46, at 10:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 19 37 to January 18 19 46 and that I last saw him alive on January 18 19 46

Immediate cause of death	DURATION
Chronic myocarditis due to coronary arteriosclerosis	over 1 year
Due to /// aortitis with cardiac hypertrophy	8 yrs.
Due to /// Psychosis with cerebral arterio-sclerosis	Over 5 yrs.
Other conditions: General Paralysis, Tabetic type	Over 8 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: Injured at work?: —

23. SIGNATURE: A. E. ROLLINGER, Lt. Col., M.C., U.S.A. M.D., or other
Director, Veterans Administration
Address: Perry Point, Md. Date signed: 0-19, 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

CERTIFICATE OF DEATH

00467

Reg. Dist. No. 90

1. PLACE OF DEATH:

County Cecil

City or town Warwick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Warwick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eccleston Marsh Holden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-29-80

8. AGE: Years 65 | Months 11 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Pump maker

11. Industry or business

FATHER 12. Name John M. Holden

13. Birthplace Md

MOTHER 14. Maiden name Adrianne Bennett

15. Birthplace Md

16. Informant Mrs Elizabeth Polson

Address 124 Hudson ave Norwood Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-10-46 (month) (day) (year)

Cemetery or ~~crematory~~ Warwick Cemtry

Location Warwick Md.

18. Funeral director E. Fuller Dennis

Address Townsend Delaware

19 Jan 9 46 (Date rec'd by registrar) Irving E Burbage Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6-46 19 ..... at 4.35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-1 19 45 to 1-6- 19 46

and that I last saw h... alive on 1-6-46 19 .....

Immediate cause of death	DURATION
Coronary Thrombosis	1 wk
Due to Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J B Miller M D M. D. or other

Address Middletown Del. Date signed 1/8/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00468

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County Cecil
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 59 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil
City or town Charlestown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Florence M. Lewis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William W. Lewis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 28, 1872

8. AGE: Years	Months	Days	If less than one day
73	1	5	....hrs. ....min.

9. Birthplace Winchester Va.
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name Robert Boyd
13. Birthplace Va.

MOTHER
14. Maiden name Biera C. Allison
15. Birthplace Va.

16. Informant James L. Lewis
Address Charlestown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 6, 1946 (month) (day) (year)
Cemetery or crematory Charlestown Cemetery
Location Charlestown, Md.

18. Funeral director Lee E. Patterson & Son
Address Perryville, Md.

19. Jan 5 1946 Irene E. Dunbar Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3rd 1946, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1st 1945 to Jan 3 1946 and that I last saw h.. alive on Jan 3rd 1946

Immediate cause of death	DURATION
Chronic Valvular Heart Disease	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. F. Magraw M. D. or other
Address Perryville Md Date signed 1-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (105)

CERTIFICATE OF DEATH

00469

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 hours.
Hospital, Institution, or street address where death occurred: Union Hosp.
How long in hospital or institution? 24 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton R D 5
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John William Lofthouse

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 11, 1937

8. AGE: Years 8 | Months 8 | Days | If less than one day: hrs. min.

9. Birthplace: Perryville, Cecil co., Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Joseph Lofthouse
13. Birthplace: Perryville Md

MOTHER
14. Maiden name: Etta Matheny
15. Birthplace: Perryville Md

16. Informant: Etta Lofthouse
Address: Elkton, Md. R.D. 5

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13, 1946 (month) (day) (year)
Cemetery or crematory: Lafayette Cem.
Location: Port Deposit, Md. Route

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Jan 11 1946 (Date rec'd by registrar) H.R. Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11 1946 at 1306 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary Edema.	
Due to: Carcinosis	
non Metastasis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R L Woodward M.D.
M. D. or other
Address: Perryville Md Date signed: 1-11-46

Medical Examiner
Cecil County

(M) (1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

CERTIFICATE OF DEATH

00479

Reg. Dist. No. 90

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Colton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Helen S. Luby

3. (b) Social Security Number: none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Wm. Luby
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 14 1881
8. AGE: Years: 64 Months: Days: If less than one day: hrs. min.
9. Birthplace: Germantown Penna. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. FATHER — Name: Samuel Sharack
13. FATHER — Birthplace: Penna.
14. MOTHER — Maiden name: Hanna Tunkel
15. MOTHER — Birthplace: Penna.
16. Informant: Wm. Luby
Address: Colton Md.
17. Burial (Burial, cremation, or removal, which?) Date thereof Jan 15 1946 (month) (day) (year)
Cemetery or crematory: St. Mary
Location: New Castle Md
18. Funeral director: Edward Fulton
Address: Millington Md
19. Jan 15 1946 (Date rec'd by registrar) Irving Burke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 1946, at 5 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 1945, to Jan 13 1946
and that I last saw h alive on Jan 5 1946

	DURATION
Immediate cause of death:	
1. Cerebral Hemorrhage	1 hour
Due to: Renunance	
2. Right Hemiplegia	Sept 13/45
Due to:	
Other conditions:	

(Ioclodo pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walter L. Lee M.D.
M. D. or other
Address: Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

00421

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22
Hospital, institution, or street address where death occurred: Union Hospital
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Elkton Md County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Martha Ann Lynch

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

B.(b) Name of husband or wife: Joseph W Lynch
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 20 1861

8. AGE:

Years	Months	Days	If less than one day
84	5	3	hrs. min.

9. Birthplace: Smyrna Kent Delaware
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: Benjamin Tanner
13. Birthplace: no information

MOTHER
14. Maiden name: Melvina Brown
15. Birthplace: no information

16. Informant: Evans S Lynch
Address: Elkton Md RD 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 7 1946 (month) (day) (year)
Cemetery or crematory: Bethel Cemetery
Location: near Chesapeake City Md
18. Funeral director: H. W. Pippin
Address: Elkton Md

19. June 26 1946 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 1946, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1925, to Jan 23 1946 and that I last saw h... alive on Jan 23 1946

Immediate cause of death	DURATION
Cardio renal vascular degeneration	
Due to	
Due to	
Other conditions: Arteriosclerosis General	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Elkton Md Date signed 1/24/46

(M) (I) (T)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83 C

06472

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residsnce of mother) Prince Geo's.
State: Maryland County: Unknown
City or town: Tuxedo
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5904 Beecher St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: MANN, William

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Gertrude Mann
6.(c) If alive, give age: ?

7. Birth date of deceased (mo., day, yr.): October 17, 1890

8. AGE: Years	Months	Days	If less than one day
55	3	13	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: —

FATHER
12. Name: William Mann
13. Birthplace: Glasgow, Scotland

MOTHER
14. Maiden name: Sarah Davies
15. Birthplace: Glasgow, Scotland

16. Informant: Records - Veterans Administration
Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: January 30, 1946 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery,
Location: Washington, D. C.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Jan. 30 1946 (Date rec'd by registrar) Irene E. Douglas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1946 at 12:30A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17, 1946 to January 30 1946
and that I last saw him alive on January 30 1946

	DURATION
Immediate cause of death: Thrombosis, Cerebral	8 hrs.
Due to: Arteriosclerosis, Cerebral	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: Cerebral Thrombosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, LT. COLL., MC, M.O.I.C. Center DIR.
Address: Vets. Admin., Perry Point, Md. Date signed: 1-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

00473

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lawrence A. Neff

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara E. Neff
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): December 8, 1868

8. AGE: Years	Months	Days	If less than one day
77	1	7	hrs. min.

9. Birthplace: Quarryville, Lancaster Co., Pa. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: David Neff
13. Birthplace: Lancaster Co., Pa.

MOTHER
14. Maiden name: Rebecca Isburn
15. Birthplace: Lancaster Co., Pa.

16. Informant: Clara E. Neff
Address: Perryville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 19, 1946 (month) (day) (year)
Cemetery or crematory: Principio Cemetery
Location: Principio Furnace, Maryland
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. Jan. 16 1946 (Date rec'd by registrar) Irma E. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15 1946 at 4:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 1946, to January 15 1946 and that I last saw him alive on January 15 1946

Immediate cause of death	DURATION
Cerebral Haemorrhage	4 da.
Due to	
Due to	
Other conditions: General Arteriosclerosis	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville, Md. Date signed: 1-16-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00474

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 11 mo. 26 da.
Hospital, Institution, or street address where death occurred:
Veterans Administration Hospital
How long in hospital or institution? (Same as above) Perry Point, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) No known address
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: PARKER, Clarence S.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorded

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 12, 1877

8. AGE:	Years	Months	Days	If less than one day
	68	5	26	— hrs. — min.

9. Birthplace: Boston, Mass. (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration Hospital Perry Point, Md.
17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof: January 14, 1946 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore, Md.
18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre de Grace, Md.
19. Jan. 14 1946 (Date rec'd by registrar) Irene E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 7 1946, at 7:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1942, to January 7 1946
and that I last saw him alive on January 7 1946

	DURATION
Immediate cause of death: Myocardial Degeneration due to	
coronary arteriosclerosis	Over 6 months
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis, with right Hemiplegia	Over 3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —
Autopsy results: Not performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: C. E. TROLLINGER, Lt.Col., M.C. Clinical Director, Acting for the Manager
Address: Veterans Administration Perry Point, Md.
M. D. or other
Date signed: 1-10-46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 dys
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 30 dys

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil 11475
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary M. Pierce

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 17 1874

8. AGE:

Years	Months	Days	If less than one day
71	4		hrs. min.

9. Birthplace: Rock Spring Cecil Co. Md.
(Town, county, and state)
10. Usual occupation: Houseworks
11. Industry or business
FATHER 12. Name: Edwin R. Pierce
13. Birthplace: Md.
MOTHER 14. Maiden name: June Blank
15. Birthplace: Pa
16. Informant: Mrs Russell Reynolds
Address: Conowingo Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18 1946 (month) (day) (year)
Cemetery or crematory: Brookview
Location: Rising Sun Md.
18. Funeral director: J. E. Tyson.
Address: Rising Sun Md
19. 1/18 1946 (Date rec'd by registrar) C. M. Worthington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 15th 1946, at 4:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15th 1945 to Jan 15 1946
and that I last saw h.. alive, on Jan 14 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	unknown
Due to: Arteriosclerosis - general	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T. H. McKnight M. D. or other
Address: Elkton - Md Date signed: Jan 15 - 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

(154?) 06[illegible]

1. PLACE OF DEATH

County Cecil Registration Dist. No. 98

Village or City Cardsville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred [illegible] yrs. 10 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Lewis S. Rhoades If U. S. Veteran, specify WAR

(a) Residence: No. Cardsville, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) June 14. 1900

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farmer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Maryland
(State or country)

FATHER

13. NAME George Rhoades

14. BIRTHPLACE (city or town) [illegible]
(State or country)

MOTHER

15. MAIDEN NAME Evelyn ?

16. BIRTHPLACE (city or town) [illegible]
(State or country)

17. INFORMANT Mr. James Rhoades
(Address) Cardsville, Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Bethel Cem. Date Jan. 21, 1946

19. UNDERTAKER Edward Williams
(Address) Millington, Md.

20. FILED Jan 19th, 1946 Irving Burke
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 18 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June, 1945, to Jan 18, 1946

I last saw h. I M alive on Jan 12, 1946; death is said to have occurred on the date stated above, at m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
1. Osteomyelitis ?	1936
2. Nephritis Terminal	Mar 1945

Other **Contributory Causes** of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) [illegible] M. D.

(Address)

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact ~~statement of OCCUPATION~~ is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenterilis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-d)

CERTIFICATE OF DEATH

00477

★ Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and in ink.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Joseph Luke Sice

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1874

8. AGE: Years	Months	Days	If less than one day
71	9		..... hrs. ..... min.

9. Birthplace: Port Deposit, Cecil Co., Md.
(Town, county, and state)

10. Usual occupation: Stonecutter

11. Industry or business: Quarry

FATHER
12. Name: John Sice
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Fahey
15. Birthplace: Ireland

16. Informant: Mrs. Mary Burlin

Address: Port Deposit, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 4 1946 (month) (day) (year)

Cemetery or crematory: Mt. Erin Cemetery

Location: Havre de Grace, Maryland

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Jan. 3, 18 46 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 1946, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 - 1940, to Dec 31 1945 and that I last saw h.. alive on December 31 1945

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs.
Due to	
Due to	
Other conditions: Arteriosclerosis	Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. Benson, M. D. M. D. or other

Address: Port Deposit Md Date signed 1/3/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

00478

Reg. Dist. No. 95

1. PLACE OF DEATH:

County: Cecil

City or town: Conowingo. Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Conowingo. Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James A. Smith

3.(b) Social Security Number 220-09-4146

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	Divorced

6.(b) Name of husband or wife: Martha Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years	Months	Days	If less than one day
53			hrs. min.

9. Birthplace: Richmond Va.

(Town, county, and state)

10. Usual occupation: Tailoring

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Martha Moore

Address: Conowingo. Md. R. F. D.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan 6 1945 (month) (day) (year)

Cemetery or crematory: Mt. Zion

Location: Conowingo

18. Funeral director: J. E. Tipton

Address: Rising Sun Md

19. Jan 6- 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3- 1946 at 11:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1942 to Jan 1 1946

and that I last saw him alive on Jan 1 1946

Immediate cause of death	DURATION
Chronic Myocarditis	6yrs
Due to	
Due to	
Other conditions: Arteriosclerosis	4yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. J. Brown, M. D. M. D. or other

Address: Port Deposit, Md. Date signed 1/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

C0479

Reg. Dist. No. 95

1. PLACE OF DEATH:
County Cecil Co.
City or town Rising Sun Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Cecil Co.
City or town Rising Sun Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harry L. Woodrow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1869

8. AGE:

Years	Months	Days	If less than one day
77		16	hrs. min.

9. Birthplace Powlandville Md.
(Town, county, and state)
10. Usual occupation Merchant
11. Industry or business

FATHER
12. Name Stephen John Woodrow
13. Birthplace Powlandville Md.

MOTHER
14. Maiden name Elonora Nesbitt
15. Birthplace Port Deposit Md.

16. Informant Mrs Nelson Jones
Address Rising Sun Md.

17. Burial / Date thereof Jan 27 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory West Nottingham Friends Cemetery
Location Near Colora Md.

18. Funeral director J. E. Tyson
Address Rising Sun Md.

19. Jan 28 1946 H. L. Mitchell Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1945 to Jan 24 1946 and that I last saw him alive on Jan 23 1946

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to Chronic Myocarditis	
Due to & Fibrillation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Woodrow M.D. M. D. or other
Address Rising Sun Md. Date signed 1-20-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

06480

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Celbln - (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Aug 21, 1944

Hospital, institution, or street address where death occurred: Union Memorial - Celbln Md.

How long in hospital or institution? Since Aug 21, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East - Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Yerbey - Mrs Jennie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Clinton Yerbey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 25, 1864

8. AGE: Years	Months	Days	If less than one day
81	10	10	..... hrs. ..... min.

9. Birthplace: Penna (Town, county, and state)

10. Usual occupation: Wife

11. Industry or business

FATHER — 12. Name: Eaton Saylor

FATHER — 13. Birthplace: Penna

MOTHER — 14. Maiden name: Rachel Crowl

MOTHER — 15. Birthplace: Penna.

16. Informant: Horace Perkins

Address: Watching Ave R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 7-46 (month) (day) (year)

Cemetery or crematory: Rose Bank Calvert

Location: Calvert Md

18. Funeral director: J. E. Pierson

Address: Rising Sun Md

19. Jan 5 1946 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 4, 1946, at 9 40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 21, 1944 to Jan 4, 1946

and that I last saw h... alive on Jan 3 1946

Immediate cause of death	DURATION
Bron Pulmonary oedema	24 hrs
Due to Bronchial Pneumonia	9 days
Due to	
Other conditions Arterio sclerosis - Aug 21 1944 (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. A. Cumbertt M.D. M. D. or other

Address: North East Md Date signed: Jan 4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING